STATE OF MICHIGAN

COURT OF APPEALS

SHARON SMITH,

Plaintiff-Appellant,

V

DENNIS MARTIN JOY, M.D. and CHARLEVOIX AREA HOSPITAL,

Defendants-Appellees.

UNPUBLISHED
September 27, 2005

No. 254324
Charlevoix Circuit Court
LC No. 02-144119-NH

Before: Meter, P.J., and Murray and Schuette, JJ.

PER CURIAM.

Plaintiff appeals from the trial court's order granting defendants' motion for summary disposition and motion to strike plaintiff's first expert witness. We affirm in part, reverse in part, and remand for further proceedings.

Plaintiff suffered a serious laceration as a result of falling off a horse. Defendant Dr. Dennis Joy treated plaintiff in the emergency room. Dr. Joy is board certified in family medicine but works in the emergency room about seventy percent of his professional time. Dr. Joy cleansed plaintiff's wound and sutured the laceration. Dr. Joy did not prescribe any antibiotics for plaintiff. A week later, when plaintiff went to have her sutures removed, she was admitted to the hospital because the wound was infected. Plaintiff had to have the wound surgically reopened and drained and was in the hospital for about a week.

Plaintiff sued defendants, and she now argues that the trial court erred when it granted summary disposition to defendants on the basis that plaintiff's medical expert, Dr. Richard Friers, was not able to testify concerning a local standard of care. We agree. We review a motion for summary disposition de novo. *Maskery v Univ of Michigan Bd of Regents*, 468 Mich 609, 613; 664 NW2d 165 (2003). We also review questions of statutory interpretation de novo. *Cox v Flint Bd of Hosp Managers*, 467 Mich 1, 16; 651 NW2d 356 (2002).

MCL 600.2912a addresses the standard of care required for both general practitioners and specialists. MCL 600.2912a(1) states:

> Subject to subsection (2), in an action alleging malpractice, the plaintiff has the burden of proving that in light of the state of the art existing at the time of the alleged malpractice:

> (a) The defendant, if a general practitioner, failed to provide the plaintiff the recognized standard of acceptable professional practice or care in the community in which the defendant practices or in a similar community, and that as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.
>
> (b) The defendant, if a specialist, failed to provide the recognized standard of practice or care within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances, and as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.

Both our Supreme Court and this Court have held that the standard of care for a general practitioner is a local standard of care while the standard of care for a specialist is a national standard of care. See e.g., *Bahr v Harper-Grace Hosp*, 448 Mich 135, 138; 528 NW2d 170 (1995), and *Cudnik v William Beaumont Hosp*, 207 Mich App 378, 383; 525 NW2d 891 (1994). Recently, in *Cox, supra*, our Supreme Court addressed the standard of care for nurses. In a footnote, the Court stated:

> The statutory standards of care set forth in MCL 600.2912a are often referred to as the "general" or "local" standard of care for general practitioners and the "national" standard of care for specialists. See e.g., *Bahr, supra* 138. The term "national," however, is not an accurate description of the statutory standard of care for specialists. The plain language of subsection (b) states that the standard of care is that "within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances." MCL 600.2912a . . . . Under the plain language of the statute, then, the standard of care for both general practitioners and specialists refers to the community. [*Cox, supra* at 17 n 17.]

The trial court found that, based on the language in *Cox*, Dr. Friers was not qualified under the statute because he practiced in a metropolitan area and was not familiar with the standard of care in Charlevoix or a similar community.

We conclude that the language in *Cox* clarified what the plain language of the statute already addressed: mainly, that, in evaluating the standard of care for a specialist, courts are not to look solely to a national standard of care. In evaluating the language of a statute, the primary goal is to give effect to the Legislature's intentions. *Decker v Flood*, 248 Mich App 75, 82; 638 NW2d 163 (2001). The first source for determining the Legislature's intent is the specific language of the statute. *Id*. If the language is unambiguous, the Legislature is presumed to have intended the meaning expressed, and judicial interpretation is not permitted. *Id.* The plain language of the statute provides that the standard of care for specialists is "the standard of practice or care within that specialty," a national standard, that is evaluated "in light of the

facilities available in the community or other facilities reasonably available under the circumstances." MCL 600.2912a(1)(b). While the standard of care for a specialist may be considered nationwide ("within that specialty" can only relate to a national standard),[1] the statute additionally instructs trial courts to evaluate this standard of care in light of the resources available in the community in which the specialist is practicing. The standard thus involves a two-step process. The holding in *Cox* recognized this. *Cox* did not state that the national standard of care for specialists was abandoned, only that the standard of care refers also to the resources of the community.[2]

Accordingly, we conclude that the trial court erred in holding that Dr. Friers was not qualified to give standard of care testimony in this case. Dr. Friers testified in his deposition that he spent eighty to ninety percent of his professional time treating patients, including patients that suffered from traumatic wounds, in the emergency department. Dr. Friers is also board certified as a specialist in emergency medicine and family practice medicine. Therefore, Dr. Friers is qualified to testify with regard to the standard of care required of a board certified family practitioner who is practicing the specialty of emergency medicine, which corresponds to Dr. Joy's situation at the time of the alleged malpractice.[3]

Under the statute, Dr. Friers must also be able to testify about the standard of care in light of the resources available in the community. Although Dr. Friers testified that he was from a metropolitan area and had never been to the Charlevoix Area Hospital, the alleged malpractice in this case involved a failure to administer antibiotics, a procedure that hospitals in metropolitan areas and rural areas would routinely perform. In fact, deposition testimony showed that the antibiotics were available in the community of Charlevoix because plaintiff was eventually given them when she was admitted to the hospital. Therefore, we find that Dr. Friers could testify concerning the standard of care required in this case. The trial court erred in granting summary disposition on this basis.

Defendants argue two alternative reasons, which were rejected by the trial court, to affirm the trial court's grant of summary disposition. See *Middlebrooks v Wayne Co*, 446 Mich 151, 166 n 41; 521 NW2d 774 (1994) (stating that an appellee may argue alternative grounds for affirmance that the trial court rejected). Defendants argue that plaintiff did not establish a

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[1] See, generally, *Naccarato v Grob*, 384 Mich 248, 253-254; 180 NW2d 788 (1970) (indicating that "reliance of the public upon the skills of a specialist and the wealth and sources of his knowledge are not limited to the geographic area in which he practices").

[2] Further, we note, from our research, that no published Michigan case law has cited *Cox* as holding that specialists are to be held to a local standard of care.

[3] Defendants argue that Dr. Joy was really not a specialist but a general practitioner practicing family medicine. This argument is contrary to defendants' position on other issues in the case. In any event, Dr. Joy was a family medicine practitioner practicing emergency medicine at the time of the alleged malpractice. This Court has recognized that emergency medicine is a medical specialty. *Carolyn v Mut of Omaha Ins Co*, 220 Mich App 444, 447; 559 NW2d 407 (1996). As such, defendants' argument that Dr. Joy was acting as a general practitioner is without merit.

genuine issue of material fact with regard to causation and that Dr. Friers is not qualified to give standard of care testimony because he does not practice family medicine. The trial court denied summary disposition with regard to both of these arguments, and we affirm the trial court's holdings.

To prove causation in a medical malpractice case, a plaintiff must show cause in fact and legal cause. *Craig v Oakwood Hosp*, 471 Mich 67, 86; 684 NW2d 296 (2004). "Generally, an act or omission is a cause in fact of an injury only if the injury could not have occurred without (or 'but for') that act or omission." *Id*. at 87. To prove cause in fact, a plaintiff does not have to show that the defendant's act or omission was the sole cause of injury, but a plaintiff has to show more than that the defendant's conduct may have caused the injury. *Id*. A plaintiff can establish cause in fact by presenting "'specific facts that would support a reasonable inference of a logical sequence of cause and effect.'" *Id*., quoting *Skinner v Square D Co*, 445 Mich 153, 174; 516 NW2d 475 (1994). To show legal cause, "the plaintiff must show that it was foreseeable that the defendant's conduct 'may create a risk of harm to the victim, and . . . [that] the result of that conduct and intervening causes were [sic] foreseeable.'" *Weymers v Khera*, 454 Mich 639, 648; 563 NW2d 647 (1997), quoting *Maning v Alfono*, 400 Mich 425, 439; 254 NW2d 759 (1977).

We find that plaintiff presented sufficient evidence of causation to withstand a motion for summary disposition. Dr. Friers testified that he believed that plaintiff was at a high risk for infection based on the nature of her wound. Dr. Friers also testified that he believed that, more likely than not, the wound infection could have been prevented with a broad-spectrum antibiotic and that the failure to give antibiotics at the emergency room increased plaintiff's risk of infection more than fifty percent. Defendant presented affidavits from various physicians who had treated plaintiff that stated that they did not believe antibiotics would have prevented plaintiff's complications. However, this simply creates an issue of fact for a jury to decide. Therefore, the trial court did not err in declining to grant summary disposition.

Defendants also argue that Dr. Friers is not qualified to render standard of care testimony because he does not meet the requirement of MCL 600.2169 that he devoted a majority of his practice in the year before the alleged malpractice to the same specialty as Dr. Joy. We disagree.

MCL 600.2169(1)(b) requires that a standard of care expert have,

> [s]ubject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed, and if that party is a specialist, the active clinical practice of that specialty.
>
> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed, and, if that party is a specialist, an accredited health professional program or accredited residency or clinical research program in the same specialty.

"The statute 'requires an expert witness to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice.'" *Hamilton v Kuligowski*, 261 Mich App 608, 611; 684 NW2d 366 (2004), quoting *Tate v Detroit Receiving Hosp*, 249 Mich App 212, 220; 642 NW2d 346 (2002).

Dr. Joy is board certified in family medicine but he practices emergency medicine the majority of his professional time. Dr. Joy also is the director of the emergency department at defendant hospital. At the time of the alleged malpractice, Dr. Joy was a board certified family practitioner practicing emergency medicine. Dr. Friers is board certified in family medicine and emergency medicine and he spent the majority of his clinical time practicing emergency medicine. The purpose of the statutory requirement is, in part, to ensure "that expert witnesses actually practice or teach medicine. In other words, to make sure that experts will have firsthand practical expertise in the subject matter about which they are testifying." *Tate, supra* at 219 (internal citations omitted). The statutory requirement and its purpose are met in this case, and the trial court did not err in finding that Dr. Friers was qualified to testify under MCL 600.2169(1)(b).

Plaintiff also argues that the trial court erred in striking her first expert witness because he was not board certified in family medicine. We disagree. In interpreting MCL 600.2169(1)(a), the Supreme Court recently held that the statute "requires that the expert witness 'must be' a specialist who is board certified in the specialty in which the defendant physician is also board certified." *Halloran v Bhan*, 470 Mich 572, 579; 683 NW2d 129 (2004). The Court held that MCL 600.2169 imposes two requirements for standard of care experts. *Id*. at 578. The first requirement compares the specialties of the defendant physician and the standard of care expert. If the defendant physician was acting in a specialty at the time of the alleged malpractice, the standard of care expert must also work in the same specialty. *Id*. at 578-579; MCL 600.2169(1)(a). Then, for the second requirement, if the defendant doctor is determined to have a board certified specialty, the standard of care expert must also share this board certification. *Halloran, supra* at 578-579.

Plaintiff's first expert witness met the first requirement of the statute because he was board certified in emergency medicine. However, Dr. Joy was practicing emergency medicine as a board certified family practitioner at the time of the alleged malpractice. Plaintiff's first expert was not board certified and did not have any training or experience in family medicine. Therefore, the trial court did not err in striking plaintiff's first expert witness. Defendants argue, for the first time on appeal, that because this expert was not a proper standard of care expert, plaintiff's affidavit of merit was insufficient and the proper remedy was a dismissal without prejudice, without tolling the statute of limitations. Although defendants can argue on appeal alternate theories for affirmance that the trial court rejected, *Middlebrooks*, *supra* at 166 n 41, this issue was not raised, addressed, or decided by the trial court and therefore is not preserved for appellate review. *ISB Sales Co v Dave's Cakes*, 258 Mich App 520, 532-533; 672 NW2d 181 (2003). Accordingly, we decline to address that issue.

Affirmed in part, reversed in part, and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Patrick M. Meter
/s/ Christopher M. Murray
/s/ Bill Schuette